

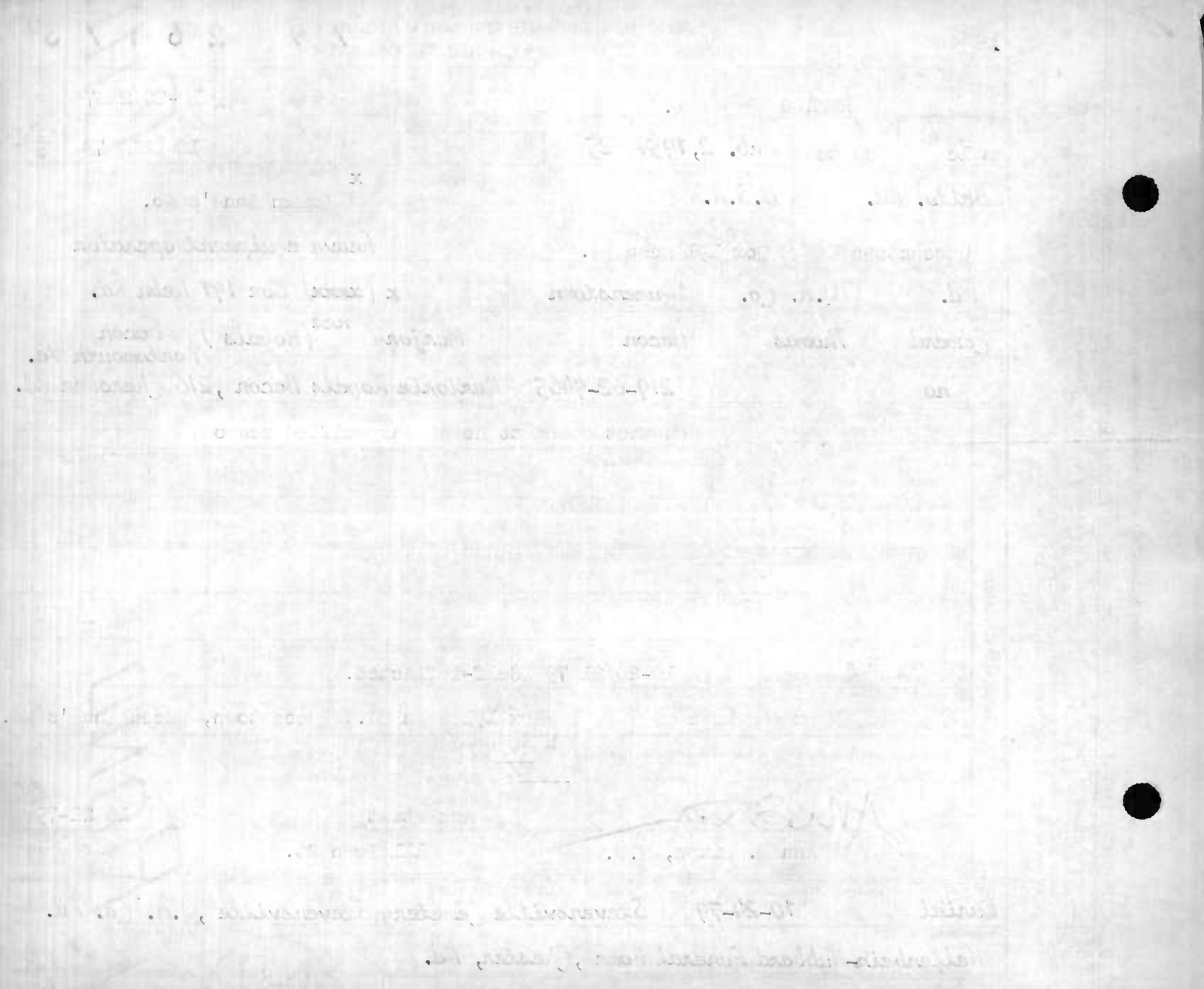


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26173	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) <b>RONALD L. BACON</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10-20/21 79		2b. HOUR <b>M</b>			
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 2, 1954</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>25</b>	7. IF UNDER 1 YR. MONTHS DAYS <b>10 21</b>	8. IF UNDER 24 HRS. HOURS MIN <b>11:50</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 21 1979</b>		2d. HOUR <b>a</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's Co. MD.</b>					
10. CITY OR TOWN OF DEATH <b>Queenstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Box 191 Kebn Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>heavy equipment operator</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Q.A. Co.</b>		13c. CITY OR TOWN <b>Queenstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>(home) Box 191 Kebn Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Thomas Bacon</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marjory nee (Royals) Bacon</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>219-62-9465</b>		17. INFORMANT ADDRESS <b>Marjorie Royals Bacon, 216 Cherokee Rd. Portsmouth Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound to head (rifle)</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>9552</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 10-20/21 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) <b>Self-inflicted.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Box 191 Kebn Rd., Queenstown, Queen Anne's Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>10-22-79</b>		MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-24-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stevensville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stevensville, Q.A. Co. Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Helfenbein-Hubbard Funeral Home, Chester, Md.</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE 			

NOT 29 1979



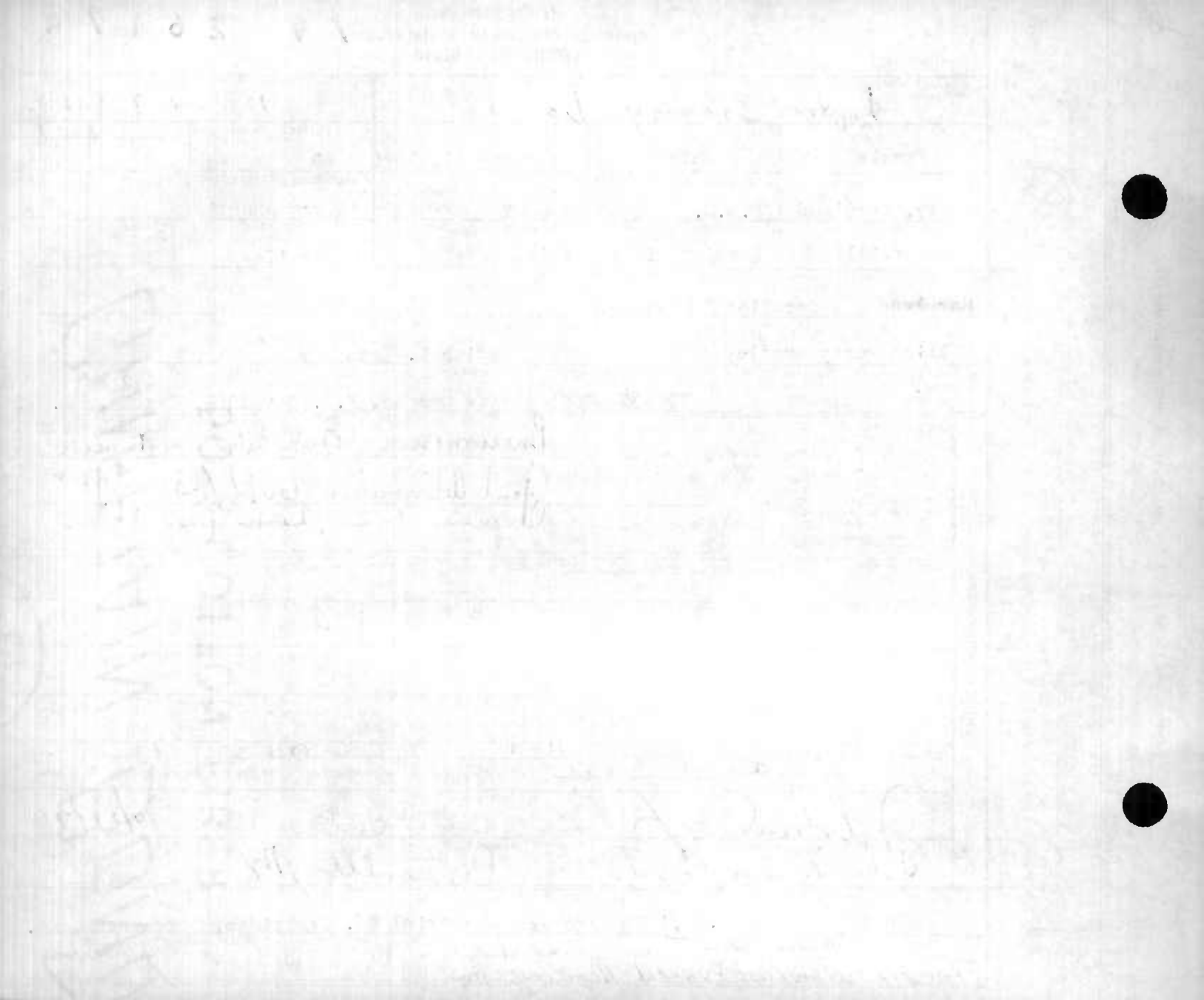
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - FOR STATE REGISTRAR					7 9 2 6 1 7 4 CERTIFICATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
Lydia Bradley Donoho					10 - 27 7 12 <sup>30</sup> PM					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		
Female		White		February 19, 1896		83 YRS.		MONTHS DAYS HOURS MIN.		
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Airey, Maryland		U.S.A.				Queen Anne MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Centerville		Corsica Hills Nursing Home				Housewife		Own Home		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland					Caroline		Preston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
William Perry Bradley					Edith Lr. Lecompte					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					216-32-9760B		Bryce Donoho, P.O. Box 1381, Easton, Md. 21601			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4370 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia, Bronchial DUE TO, OR AS A CONSEQUENCE OF (c) Gent Arteriosclerosis Cor. A-S Impairment Fracture, Lumbar Spine APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mch 5 yrs 1 year										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 11-7 1979, to Oct. 27 1979, that (I) (we) lost saw the deceased alive on Oct. 26 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		22c. DATE SIGNED			
John R. Smith, Jr.							10/27/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
John R. Smith, Jr.					Centerville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			Oct. 30, 1979		Dorchester Memorial Pk.		Cambridge, Dorchester, Md.			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Michael A. Edwards Frampton - Hawkins Funeral Home - Box 23 md					OCT 30 1979		L. J. McCreedy			

MEDICAL CERTIFICATION



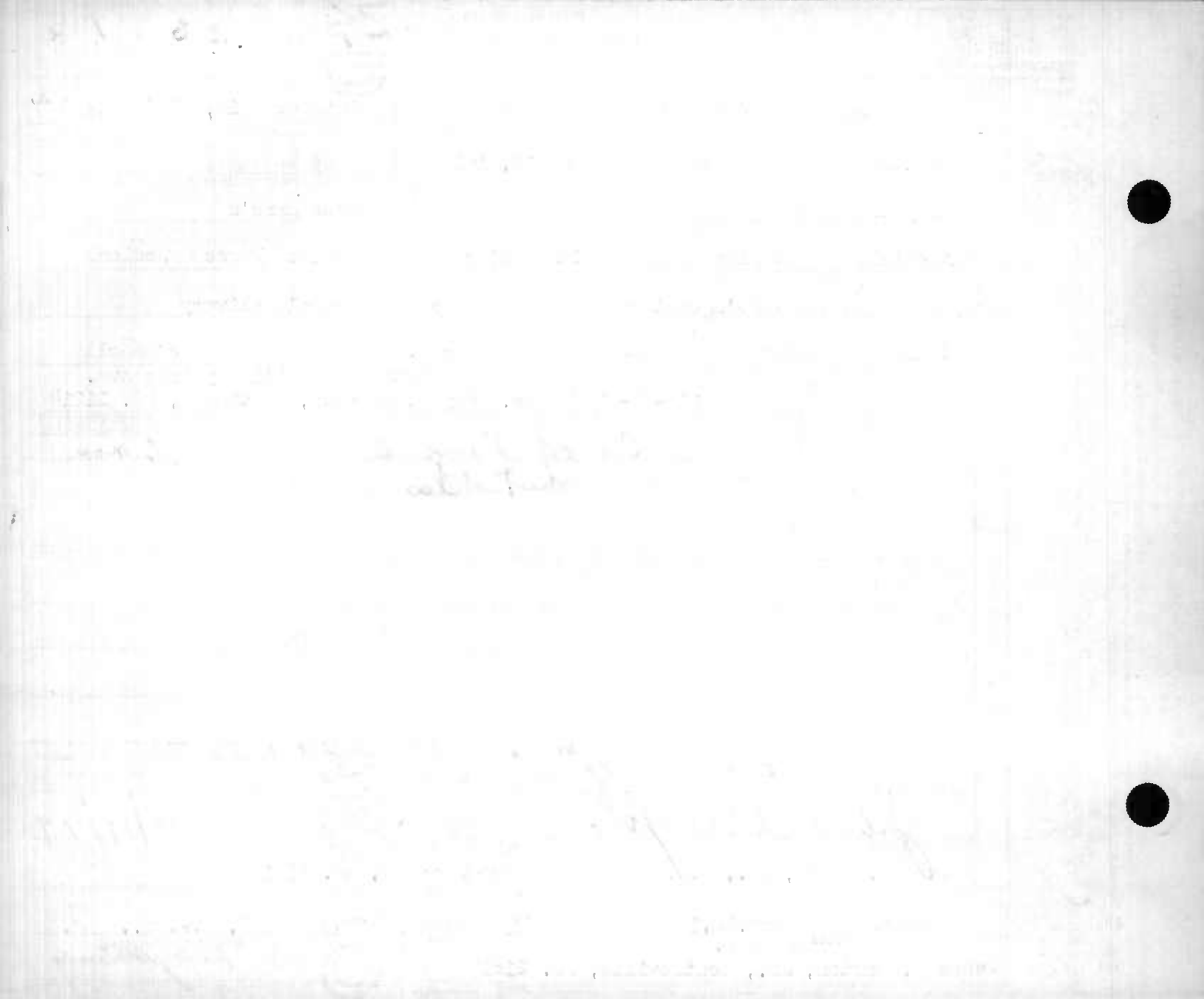
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 6 1 7 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes Josephine EMERSON				2a. DATE OF DEATH MONTH DAY YEAR October 18, 1979		2b. HOUR 1:50 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 21, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's MD.	
10. CITY OR TOWN OF DEATH Centreville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Corsica Hills Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Medical	
13a. STATE Maryland		13b. COUNTY Queen Anne's		13c. CITY OR TOWN Centreville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Howard Emerson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Mary McDonnell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 215-62-0347		17. INFORMANT Sister Mrs. Mary M. Zelenka, Baltimore, Md. 21214				17a. ADDRESS 5110 Tyndale Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of Lung c</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>metastases</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 16</u> , 19 <u>79</u> , to <u>Oct. 1</u> , 19 <u>79</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>Oct. 17</u> , 19 <u>79</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I/we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.							
22b. SIGNATURE <u>John R. Smith, Jr.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Smith, Jr., M.D.		22e. ADDRESS Centreville, Md. 21617					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 20, 1979		23c. NAME OF CEMETERY OR CREMATORY Holy Family Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Church Hill, Q.A.Co., Md.	
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 23 1979		25b. REGISTRAR'S SIGNATURE <u>Henry A. Brady</u>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Margaret Maggie Norris</i>			2a. DATE OF DEATH Month <i>10</i> Day <i>30</i> Year <i>79</i>			2b. HOUR M <i>1</i>					
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>8/8/195</i>		6. AGE (In years last birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS <i>8</i> DAYS <i>10</i>		IF UNDER 24 HRS HOURS <i>10</i> MIN <i>10</i>	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Queen Anne</i> Md.					
10. CITY OR TOWN OF DEATH <i>Centreville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Route #1 Box 350</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Queen Anne</i>		13c. CITY OR TOWN <i>Centreville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Route #1 Box 350</i>			
14. FATHER'S NAME First <i>Phillip</i> Middle <i>Simpson</i> Last <i>Mildred</i>		15. MOTHER'S MAIDEN NAME First <i>Williams</i> Middle <i>Nicks</i> Last <i>Nicks</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>2</i>		16b. SOCIAL SECURITY NO. <i>220 05-4877A</i>		17. INFORMANT <i>Blanche Nicks</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4029</i> IMMEDIATE CAUSE (a) <i>Hypertensive C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1 mo.</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John R. Smith, Jr.</i>		22c. DATE SIGNED <i>11-6-79</i>		22d. PHYSICIAN'S NAME (Type) <i>John R. Smith, Jr. M.D.</i>							
22e. ADDRESS <i>Centreville, Md. 21617</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>11/3/79</i>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <i>Sandtown</i>		23d. LOCATION (City or Town) (County) (State) <i>Hillsboro 86 MD</i>					
24. FUNERAL DIRECTOR <i>George H. Rashfield Easton and</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 26 1979</i>		25b. REGISTRAR'S SIGNATURE <i>George H. Rashfield</i>							







1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Margaret Meigs Howard								10-27-79								11:30 A M	
3. SEX		F		4. RACE		W		5. DATE OF BIRTH		MONTH		DAY		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
								12-14-1888								90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Pa.		7b. CITIZEN OF WHAT COUNTRY?		USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		QUEEN ANNES		MD			
10. CITY OR TOWN OF DEATH		Centerville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Cresca Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		POCAHONTOS DR					
14. FATHER'S NAME		JOHN		MIDDLE		Meigs		15. MOTHER'S MAIDEN NAME		MADON		MIDDLE		Butcher			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		NO		16b. SOCIAL SECURITY NO.		1		17. INFORMANT		Margaret H. Howard		ADDRESS		#13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Cerebral Thrombosis		4029		(b)		DUE TO, OR AS A CONSEQUENCE OF		H.C.V.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		6 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(c)		DUE TO, OR AS A CONSEQUENCE OF										10 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1978, to Oct. 27, 1979, that (I) (we) last saw the deceased alive on Oct. 26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		10/27/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		John R. Smith, Jr.		22e. ADDRESS		Centerville, Md		22f. ZIP CODE		21617							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		CEMATION		10/29/79		H. Hancock		Brentwood PG MD			
24. FUNERAL DIRECTOR		John F. Home		ADDRESS		Chinpo, Md		25a. DATE REC'D. BY REGISTRAR		OCT 30 1979		25b. REGISTRAR'S SIGNATURE		H. Hancock			

10-10-10



Report of the

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	KNOWN ESTIMATED	<input type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
Thelma Cecil Howell					10	30	19	79		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
female	white	Oct. 19, 1916	68 YRS.			10	30	19	79	12:40 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	<input type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> WIDOWED	<input checked="" type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.	USA					Queen Anne's County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Stevensville	Queen Anne's Colony	H. Wife		Home						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS						
Maryland	Queen Anne's	Stevensville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PO Box 234						
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME									
Charles - Kaiser	Sarah - Green									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	7740 Dean Crest Dr. Gaithersburg, Md. 20760							
no	219-68-9316	Douglas Howell								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Doxepin intoxication</u>										
9503										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		10/29/1979 P.M.		self ingested						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE
		at home		Queen Anne's Colony		Q.A. Co., Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED						
Hormez R. Guard, M.D.		Assistant		10/31/79						
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS								
Hormez R. Guard, M.D.		111 Penn Street, Baltimore, MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN				
Burial	Nov. 2, 1979	Parklawn		Rockville		Mont. Md.				
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Francis H. Barber Laytonsville, Md. 20760		NOV 05 1979		L. H. Brady						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR - STATE REGISTRAR		7 9 2 6 1 7 9		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Rose Mountain Jordan</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 28 79</b>		2b. HOUR PM <b>1:20 M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 23 1882</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's MD</b>			
10. CITY OR TOWN OF DEATH <b>Centreville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Corsica Hills Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Arnold</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Mountain</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bridget Dally</b>		13e. STREET ADDRESS <b>1434 Ritchie Hwy.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>215 76 0318</b>		17. INFORMANT ADDRESS <b>CHARENCE JOEDAN Jr. # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF <b>ASNA</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>5 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 4, 1979</b> to <b>10-28</b> , 19 <b>79</b> , that (I) <b>we</b> last saw the deceased alive on <b>Oct 27</b> , 19 <b>79</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>we</b> (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/28/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Smith, Jr.</b>		22e. ADDRESS <b>Centreville, Md 21617</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>10/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>			
24. FUNERAL DIRECTOR NAME <b>Funeral Chapel</b>		ADDRESS <b>Chesapeake, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 6 1 8 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE B. MERCER			2a. DATE OF DEATH MONTH DAY YEAR 10-3-79			2b. HOUR 3:20 A M			
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 11 6 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH QUEEN ANNE MD			
10. CITY OR TOWN OF DEATH CENTREVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CORSIKA HILLS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY Queen Anne's		13c. CITY OR TOWN Centreville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 101 POWELL STREET	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN JOHNS MERCER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHNS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-07-1388		17. INFORMANT ADDRESS ANN RITCHETT SAME					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Malaria DUE TO, OR AS A CONSEQUENCE OF (b) A.S.N.A., HCV D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos 10 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 10, 1979, to Oct 2, 1979, that (I) (I) last saw the deceased alive on Oct 2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John R. Smith, Jr.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-3-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Smith, Jr.						22e. ADDRESS Centreville, Md. 21617			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/5/79		23c. NAME OF CEMETERY OR CREMATORY Centreville		23d. LOCATION CITY OR TOWN COUNTY STATE Centreville Qn. Md.		
24. FUNERAL DIRECTOR NAME EL Dashwell						ADDRESS P.O. Box 606 Easton, Md 21604		25a. DATE REC'D. BY REGISTRAR OCT 3 1979	
						25b. REGISTRAR'S SIGNATURE Rising			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>William Dudley MOORE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 31, 1979</b>			2b. HOUR <b>6:15 pm</b>					
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 5 '91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Templeville, md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's</b> MD.					
10. CITY OR TOWN OF DEATH <b>Centerville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carissa Hills Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>md.</b>			13c. COUNTY <b>Kent</b>		13d. CITY OR TOWN <b>Millington</b>		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Moore</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate Emory</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>217-28-3711-A</b>	
17. INFORMANT ADDRESS <b>Dover, Del. 19901</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>486-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Organic Brain Syndrome.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 2</b> , 19 <b>79</b> , to <b>Oct 31</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Oct 30</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>James L. Longmore MD</b>			DEGREE			22c. DATE SIGNED <b>10-31-79</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES L. LONGMORE</b>			22e. ADDRESS <b>PENN. &amp; KIDWELL AVES, CENTREVILLE MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sudlersville, Q.A. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Edward Fellows &amp; Son</b>			ADDRESS <b>Millington</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 05 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony K. Brady</b>			

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>IDA MAE PANIERE</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <b>Oct. 2 1979</b>			2b. HOUR <b>3 A M</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>April, 24, 1915</b>	6. AGE (In years last birthday) <b>64 YRS.</b>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>Oct.</b> Day <b>2</b> Year <b>1979</b>			2d. HOUR <b>3 A M</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Queen Anne's Md.</b>			
10. CITY OR TOWN OF DEATH <b>Rd. Marydel</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Q.A.</b>		13c. CITY OR TOWN <b>Marydel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rd. # 1, Box 40</b>	
14. FATHER'S NAME First <b>Ernest</b> Middle <b>Darling</b> Last <b>Casey</b>			15. MOTHER'S MAIDEN NAME First <b>Ethel</b> Middle <b>Casey</b> Last <b>Casey</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>219-70-7915</b>		17. INFORMANT ADDRESS <b>John Paniere, as above.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>A.S.H.D</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cerebral Embolus</b> (b) <b>Ca g Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 mos.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>1 year</b> <b>2 mos.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <input type="checkbox"/>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John R. Smith, Jr.</b>		EXAMINER'S NAME (Type) <b>John R. Smith, Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10-4-79</b>		ADDRESS (Street, city, town, or county) <b>Centreville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Sudlersville Q.A. Md.</b>			
24. FUNERAL DIRECTOR <b>Edward Fellows &amp; Son, Millington, Md. 21651</b>				25a. REC'D BY REGISTRAR <b>OC 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>			

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR FILE  
IN THE



U.S. GOVERNMENT PRINTING OFFICE: 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

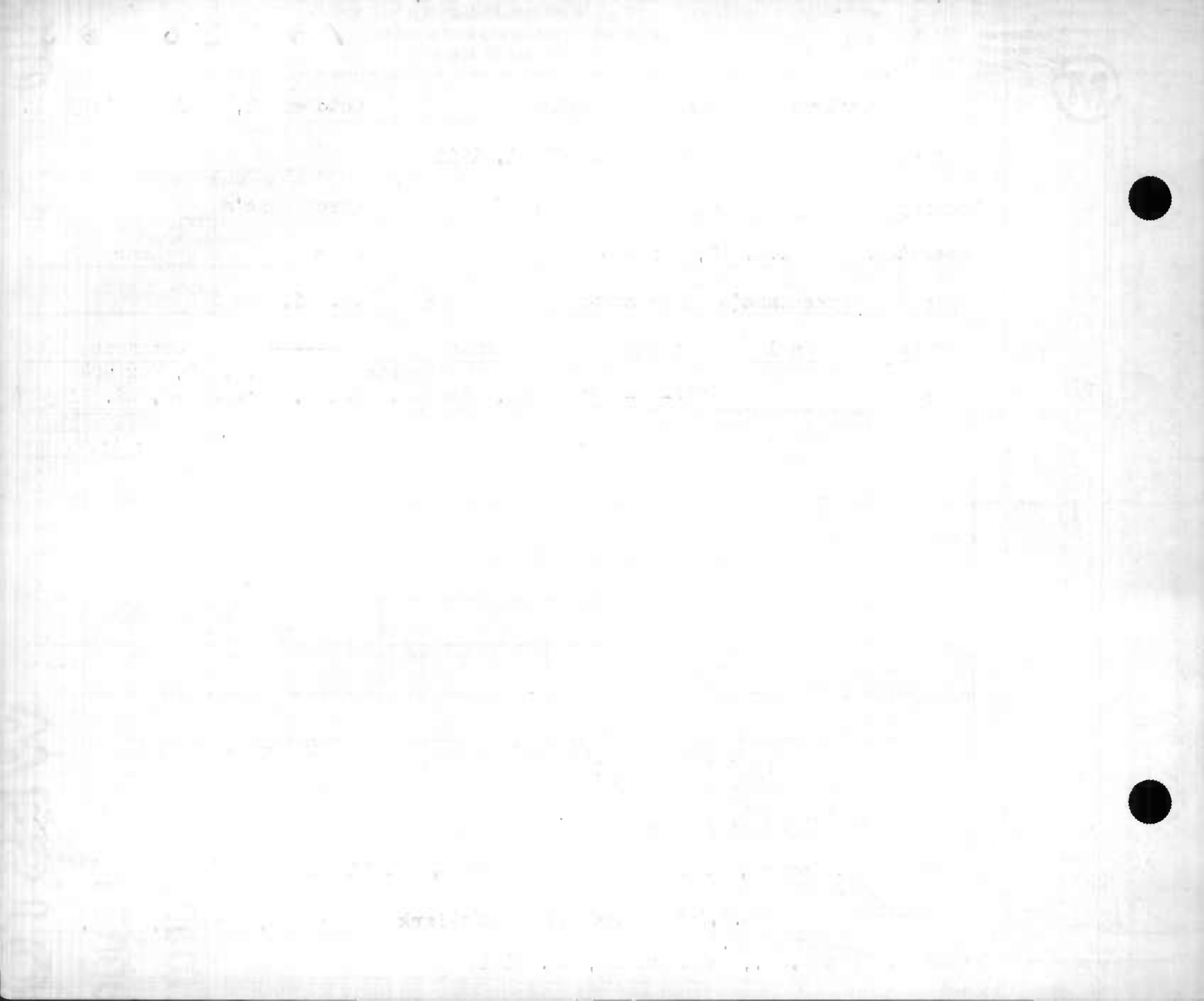
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 2 6 1 8 3						
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Gertrud Erna ROSER					2a. DATE OF DEATH MONTH DAY YEAR October 2, 1979				2b. HOUR 3:05 P.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's MD.					
10. CITY OR TOWN OF DEATH Queenstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) R.D. #2, Box 464				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Queen Anne's		13c. CITY OR TOWN Queenstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Louis Karl Herold					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma ----- Schwarze						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-46-4758		17. INFORMANT Daughter Mrs. Elsie R. Lister, Queenstown, Md. 21658							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u> 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 28</u> 19 <u>78</u> to <u>Oct 2</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>9-27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Stephen P. Carney</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-4-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				22e. ADDRESS Easton, Md. 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 5, 1979		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Easton, Talbot, Md.					
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617				25a. DATE REC'D. BY REGISTRAR OCT 10 1979				25b. REGISTRAR'S SIGNATURE <u>John M. Sydnor</u>			

BP





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 6 1 8 4

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRENE TURNER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10 9 79</b>		2b. HOUR <b>9 30 a.m.</b>	
3 SEX <b>FEMALE</b>	4 RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 24 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND STEYENSVILLE</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>QUEEN ANNE'S COUNTY MD.</b>	
10 CITY OR TOWN OF DEATH <b>CENTREVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CORSICA HILLS NURSING CENTER</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b>		13c. CITY OR TOWN <b>QUEEN ANNE'S CHESTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WALLACE TURNER</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOTTIE GRIFFIN</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNKNOWN</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-18-8433</b>		17 INFORMANT ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerosis</b> (c) <b>Diabetes mellitus</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Intoxicated</b> <b>① Chronic Brain Syndrome ② Rheumatic Heart Disease ③ Probable Intoxication</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23/78</b> , 19____, to <b>10/8/79</b> , 19____, that (I) (we) lost saw the deceased alive on <b>10/8</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>KIN K WUN</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. Kellum</b>		22e. ADDRESS <b>216 High St. Chestertown Md 21620</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/13/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BATHSWICK</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stevensville GA Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Eric L. Dashiell P.O. Box 606 E. Easton Md 21601</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 2 1979</b>		REGISTRAR'S SIGNATURE <b>Pietro McCready</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First EDNA	Middle M.	Last WINTER	2a. DATE OF DEATH Month Day Year Oct. 8, 1979		2b. HOUR 4 P	
3. SEX female		4. RACE white		5. DATE OF BIRTH August 26, 1892		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Queen Anne Md.		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) at Home River Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Art Teacher & Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Queen Anne		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last Edmund C. Haley		15. MOTHER'S MAIDEN NAME First Middle Last Mary Bevan		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 211 28 0978		17. INFORMANT David Winter
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins. years		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 7/15, 1975, to 8/6, 1975, that (I) (we) last saw the deceased alive on 8/6, 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE W. D. Benjamin		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) Wayne D. Benjamin		22e. ADDRESS Chestertown, Md. 21620		22c. DATE SIGNED 10/9/79				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 10/11/79		23c. NAME OF CEMETERY OR CREMATORY Gratin - Ferris Crematory West Chester, Pa.		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR OCT 15 1979		25b. REGISTRAR'S SIGNATURE Ruthy McCurdy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



IN SENATE,  
January 10, 1911.  
REPORT  
OF THE  
ATTORNEY GENERAL,  
JAMES C. CLARK,  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE,  
MAY 1, 1909,  
RELATIVE TO THE  
PROSECUTION OF  
THE CASE OF  
JAMES C. CLARK,  
IN THE MATTER OF  
THE ESTATE OF  
JAMES C. CLARK,  
DECEASED.